Project ECHO Dementia

CASE PRESENTATION FORM

ECHO ID

DATE CLINIC

PRESENTER

CHECK ONE NEW CASE FOLLOW-UP

PATIENT AGE GENDER: MALE FEMALE TRANSGENDER

RACE/ETHNICITY

OCCUPATION LEVEL OF EDUCATION

DIAGNOSIS? DATE OF DIAGNOSIS?

FOR HOW LONG HAS PRESENTER KNOWN PATIENT?

WHAT IS PRESENTER'S ROLE IN PATIENT'S CARE?

IF PRESENTER IS NOT PCP, DOES PATIENT HAVE A PCP?

WHO MAKES UP PATIENT CARE TEAM?

PATIENT NARRATIVE AND MAIN QUESTIONS:

CHECK ALL THAT APPLY OR RELATE TO YOUR MAIN QUESTION

Specific symptom management (insomnia, wandering, paranoia, hallucinations, etc.)

Dementia specific treatment options

Issues of Activities of Daily Living (ADLs)

Issues of Instrumental Activities of Daily Living (iADLs)

Determining the patient's diagnosis

Agitation and/or aggression

Advance care planning

Inappropriate behavior

Other(s)

BRIEF HISTORY OF PRESENT ILLNESS

Psychiatric hospitalization(s)? No Yes # of times?

Number of unsuccessful attempted placements?

ER visits in last 6 months? No Yes # of times?

Recent medical hospitalization(s)? No Yes Date? Reason?

CURRENT AND PAST MEDICAL HISTORY

Hypertension

Diabetes

Hyperlipidemia

CAD

Stroke

Seizures

Head injury

Anxiety

Depression

Hearing loss

Sleep Apnea

Delirium

Falls

Screening for pain?

Additional detail:

RELEVENT FAMILY MEDICAL HISTORY

CURRENT MEDICATIONS AND THERAPIES

Please list prescriptions, supplements and OTC meds, or paste medication list:

Does patient use a medi-set? No Yes Not sure

Any concerns about medication adherence? No Yes Not sure

MEDICATIONS AND THERAPIES THAT HAVE BEEN TRIED IN THE PAST, AND WHY STOPPED

SOCIAL HISTORY

Please describe Patient's living arrangements (Where? With whom? Who provides care?) and any concerns:

	Poor	Fair	Good	Optimal	Additional notes
Activity Level					
Nutrition					MIND or DASH diet?
Community/Family Engagement					

Sleep: Number of hours per 24-hour period?

Alcohol use? Current No Yes # drinks/day? Past No Yes # drinks/day?

Tobacco use? Current No Yes Past No Yes

Marijuana use? Current No Yes Past No Yes

Concerns about vulnerability/elder abuse? No Yes Not sure

Concerns about capacity? No Yes Not sure

For non-decisional patients, decisions made by:

DPOA Financial in place? No Yes Not sure

DPOA Medical in place? No Yes Not sure

ADVANCE DIRECTIVE in place? No Yes Not sure

CURRENT POLST in place? No Yes Not sure

DNR in place? No Yes Not sure

Financial Concerns: No Not sure Yes

Additional detail:

REVIEW OF SYSTEMS

Insomnia	Agitation	Wandering
Depression	Constipation	Drowsiness
Incontinence	Anxiety	Other:

PHYSICAL EXAM – PERTINENT FINDINGS

COGNITIVE SCREENING EXAMS: SCORE SUMMARIES (optional: attach redacted/de-identified forms)

	NORMAL	ABNORMAL	UNKNOWN
SLUMS			
GPCOG			
MMSE			
MOCA			
MINI-COG			
INFORMANT TOOL			

Neuropsychology Testing:____

PERTINENT LABS:

	NORMAL	ABNORMAL	UNKNOWN
CBC			
CMP			
A1c			
LIPIDS			
TSH			
B12			
D			
HIV			
RPR			
OTHER: (FOLATE/MMA/ HOMOCYSTEINE ETC			

Imaging:

GOALS OF CARE (What is important to the patient/family?)

Physical goals:
Psychological goals:

Emotional/social goals:
Spiritual goals:

ANY OTHER INFORMATION THAT YOU THINK IS IMPORTANT

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